MDR: M4-02-2944-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 2-22-02.
   b. The request was received on 5-7-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Medical Records
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-28-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 7-1-02. The response from the insurance carrier was received in the Division on 7-11-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 3-21-02:
   "This patient is at a primary level of care which means it is generally considered to be appropriate for injured workers immediately following the compensable injury; however,

the injured worker in this level of care may also be an early postoperative patient or may be experiencing an acute exacerbation of his or her chronic condition…The CPT Code of 99214 is an office or other outpatient visit for the evaluation and management of an established patient, which requires at least tow [sic] of these three key components;…Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family."

2. Respondent: Letter dated 7-10-02;
"1. CPT code 99214 is an E&M code, as such the descriptor for that codes [sic] governs, at least in part, the reimbursement…3. The document submitted does not meet the requirements referenced above for this CPT code…A. There is no detailed history or detailed examination. B. The medical decision-making, notated under the 'PLAN,' is not of moderate complexity because it is a repeat of the same/similar statements made in other documentation by this provider on 12/14/01, 1/11/02, and 1/25/02…For these reasons (Carrier) denied payment for the disputed date of service and cannot now authorize payment for a service not supportable by the coding."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 2-22-02.

2. The Carrier has denied the disputed date of service as reflected on the EOB as, "COD1 F, T,N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
2-22-02	99214	$71.00	$-0-	COD1 F,T,N	$71.00	MFG; Evaluation and Management (VI) (B); TWCC Rule 133.304 (c); CPT Descriptor	The Carrier has denied the disputed charges as "COD1 T,F,N". In regard to the "F" and N" denial codes., the office visits reviewed for the disputed dates of service were supportive of two of the required components for CPT Code 99214. The notes were descriptive of a detailed office visit with decision making of moderate complexity. There is no requirement on what verbiage the provider must include in each office visit. The only requirement of this code is that the minimum components be met. In regard to the denial code of "T", the carrier has not expounded on the "T" denial. TWCC Rule 133.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." The Carrier has not provided sufficient explanation of their denial of "T", as required by Rule 133.304 (c). Therefore, reimbursement is recommended in the amount of **$71.00.**
Totals		$71.00	$-0-				The Requestor **is entitled** to reimbursement in the amount of **$71.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$71.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 18th day of October 2002.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll